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ABSTRACT

The economic solvency of Community Mental Health Centers (CMHCs) is a problem that needs immediate attention. In order to study the shift in funding sources for the 40 Community Services Boards (CSBs) which administer the 114 CMHCs in Virginia, the funding sources of CMHCs, and the fee collections of the CSBs, were examined. Data revealed that since 1980, state funds, fee collections, and local funds have increased, while federal funds have been significantly cut back. To further examine fee collections (direct client, private insurance, Medicaid, and Medicare), to determine shifts in these funding sources over time, the 40 CSBs were divided into low, middle, and high groups according to the socioeconomic status of the population served by each. The data clearly indicated a significant increase in insurance reimbursements, a decrease in Medicaid collections, and a general stability for direct client and Medicare collections. The results fail to replicate the National Institute of Mental Health data reported in 1980. The increase in insurance reimbursements coupled with decreases in Medicaid has significant implications for the delivery of services in CMHCs. (BH)

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Community Mental Health Centers and Insurance Reimbursements

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Running head: CMHC AND REIMBURSEMENTS

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Abstract

This study examined the shift in funding sources for the 40 Community Services Boards (CSB) which administer the 114 Community Mental Health Centers in Virginia. Data from the Department of Mental Health and Mental Retardation were collected and revealed that since 1980 the average rate of state funds has increased by 13%, fee collections have increased by an average of 12%, local funds by 9%, while federal funds have been significantly cut back. The increase in fee collections led to a closer examination of of this revenue source. The 40 CSBs were divided into three groups (low, middle, and high) which was based on the socio-economic status of the population served by each CSB. A multivariate analysis of variance with repeated measures was performed with the various fee sources (direct client, commercial insurance, Medicaid, and Medicare). The results from the first hypothesis revealed no significant interactions between the groups over time for each of the various fee sources. The results from the second hypothesis revealed significant mean group differences for all of the fee sources. However, a breakdown of fee collections on an individual basis revealed group differences for Medicaid alone. Results from the third hypothesis revealed that during the past nine quarters Medicaid collections decreased significantly and insurance reimbursements increased significantly. Difference scores for these two sources over time were also significant. These results fail to replicate National Institute of Mental Health data reported in 1980. The significant increase in

insurance reimbursements coupled with significant decreases in Medicaid has significant implications upon the delivery of services in CMHCs. This study accentuates the need to begin an investigation of the impact these shifts in funding sources may be having upon the mental health services in our society. If this examination of our CMHCs is not initiated immediately, we run the risk of significantly reducing the mental health services to the poorest section in our society.

Community Mental Health Centers and Insurance Reimbursements

The President's Commission on Mental Health (1978) recognized the financial crisis facing mental health services and stated in its report, "These needs cannot be met unless we make basic changes in public policies and programs, particularly in how we plan, coordinate and finance mental health care" (p.5). According to the President's Commission (1978), one of the goals for the next decade will be, "to adequately finance mental health services with public and private funds" (p.9). The Mental Health Systems Act of 1980 (PL 96-398), which was based upon the President's Commission, broke new ground in the areas of client advocacy, primary prevention, rape prevention, and mental health coverage for the elderly and children. However, the new act failed to significantly address the major issue of the continued financial crisis facing the Community Mental Health Centers (CMHC). The economic solvency of CMHCs is a problem which has received little attention in the recent past. More importantly, the relationship between private and public funding has scarcely been explored. The goal of this project is to examine the economic questions facing CMHCs in our society. This research project is divided into three stages. The first stage examines the funding sources of CMHCs, specifically, the state, local, fees and federal appropriations; the second stage examines the fee collections of the Community Services Boards (CSB) and the relationship between private insurance reimbursements and other fee sources such as direct

client, Medicare and Medicaid; and the third stage of this project will examine if shifts in funding sources have affected the delivery of services. This paper will examine the first two questions and will conclude by proposing future research in the third area.

History of CMHC Funding

A short chronological history of CMHCs reveals that although minor changes in funding approaches have been initiated, the major thrust of the legislation has been toward decreased government support and increased third party reimbursements. This policy position was clearly reflected in a statement made by the former Commissioner of Mental Health and Mental Retardation in Virginia:

> "Reimbursements by clients, third parties and responsible persons for the cost of services provided by Community Services Boards must be viewed as a primary source of funding for community services. State and local appropriations are to be utilized only for expenses that are not reimbursable" (L.E. Kirven, personal communication, August 22, 1980.)

The original CMHC Act of 1963 proposed that the federal government allocate "seed" money in order to help states develop their respective CMHCs. Two years later, in 1965, the government appropriated money for staffing positions, but specifically stated that such support would be for a limited time. It was the government's intention that states would become solely responsible for the financial support of CMHCs.

In the late 60's new funding sources emerged; in 1967 the Civilian Health and Medical Program of the Uniformed Services

(CHAMPUS) was developed; in 1968 Medicare legislation was passed and in 1969 Medicaid was created (Lide, 1981). These newly enacted government sponsored health insurance programs, coupled with the private insurance plans such as Blue Cross and Blue Shield (BC-BS) were intended to unload the financial burden of CMHCs from the federal, state, and local governments and become the primary source of funding.

By 1970 the Federal government realized that state and local funds were going to be insufficient to meet the needs of CMHCs and therefore continued their support of these centers. The Community Mental Health Centers Amendment of 1970 (P.L. 91-211) enacted a number of provisions. These changes included a larger federally supported share of center construction costs; a 2-5% increase in state support for administrative costs while maintaining the $50,000 overall limit; and an increase in the time period (from 51 months to eight years) through which non-poverty and poverty areas could receive staffing grants. This new legislation was intended to enable the federal government to supplement existing funds while not becoming the primary financial source of CMHCs (National Institute of Mental Health, 1978).

In 1975, the Department of Health, Education, and Welfare published regulations and guidelines on which health service suppliers were to base their funding collection activities (National Institute of Mental Health, 1975). The regulations, while emphasizing the priority of serving a low income population, were aimed at attaining a realistic source of non-grant revenues. Federal monies were not to be the sole supporters

of mental health services. In order to receive federal support, each health service was required to provide evidence that a plan to recover the maximum reimbursement available for the services provided existed (NIMH, 1975). Only in those cases where the recipient was unable to pay were there to be no charges. Furthermore, when a third party payer is obliged and authorized to pay for services rendered "all services covered by that reimbursement plan must be billed and every reasonable effort must be made to obtain payment" (p. 16). In order to collect this new funding source the regulations outlined, "operative and ongoing procedures for identifying all recipients who were eligible for third party reimbursements" (p. 18). Thus, CMHCs found themselves faced with an inherent contradiction. They were required to provide services to those individuals unable to pay and without insurance, while at the same time maintaining a steady and sufficient supply of third party monies.

Although the government believed that a shift toward insurance reimbursements would relieve the financial strain of the CMHCs, there were those within the psychological community who felt that such an approach would have unintended negative consequences. Meltzer (1975) believed that reliance upon third party reimbursements would reinforce traditional therapeutic approaches, and result in a reduction of prevention models within the public sector. Chodoff (1972) cautioned that the type of treatment chosen would be related to insurance reimbursements, and Bevan (1971) warned that third party reimbursements would lower the incentive to produce more cost effective services. On the

other hand, directors of CMHCs, who are concerned with the financial solvency of these centers, have held a different view. As one director succinctly stated, "We've gone to a private practice model because it isn't practical to serve people who won't or can't pay" (Fisher, 1982, p.9).

Hypotheses

This study attempts to examine the critical question of shifts in funding sources of CSBs. The first part of this study investigates the changes in funding sources (state, local, fees, federal, and other) of CSBs and attempts to identify which of these funding sources has been affected by budgetary cutbacks. The second part of this study more closely examines fee collections (direct client, private insurance, Medicaid, and Medicare) in order to determine if shifts between these funding sources have occurred over time. Three hypotheses were developed:

1) No interaction exists between the three groups of CSBs (low, middle, and high income level) for each of the various fee sources over time.

2) No differences exist between the means of the three groups of CSBs for each of the various fee sources.

3) For a given fee source, no differences exist between the means considered over time.

In summary, the first hypothesis examines parallelism, the second hypothesis examines group differences, while a trend analysis is tested in the third hypothesis. These hypotheses are considered for each of the various fee sources.

Method

Subjects

The subjects in this study included the 40 CSBs in Virginia which oversee the 114 CMHCs in Virginia. Yearly budget summary sheets from 1980-1984 were obtained from the Fiscal Office of the Department of Mental Health and Mental Retardation (see Table 1). In addition, the Community Reimbursement Division of the Department of Mental Health and Mental Retardation supplied quarterly fee reports for fiscal years 1982 and 1983 and the first quarter of 1984. The fees reported included direct client, BC-BS, other insurance, Medicaid, Medicare, Champus, Title XX, Alcohol Safety Action Program (ASAP) and other. For the purposes of this study, insurance included those amounts collected from BC-BS, other insurance and Champus. The 1980 National Census was used in order to divide our sample into three distinct socio-economic groups. The low income group was comprised of 25 CSBs in which the weighted median income of the population served in that geographical area ranged up to $15,999. The middle income group consisted of seven CSBs with an income range from $16,000-$19,999. The high income group included eight CSBs in which the median income of the population in that area was $20,000 and above.

Results

The results from the first stage of this study are summarized in Table 1. The evidence clearly indicates that over the past five years federal funds have decreased significantly from 14.3% in 1980 to 4.4% in 1984, state funds and fee collections have

increased dramatically, and local money has increased very slightly.

Insert Table 1 about here

A closer examination of the percentage change, for each funding source, over the past five years (see Table 2) reveals that state funds have increased at an average rate of about 13% each year, local money at a slower rate of 9% each year, while fees are increasing at an average rate of 12% each year.

Insert Table 2 about here

This shift toward increased fee collections led to a closer examination of fee collections and the second part of this study. As can be gleaned from the results in Table 3, the mean number of dollars collected from direct clients and third party

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Insert Table 3 about here

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reimbursements have increased while Medicaid collections have remained stable and Medicare has decreased. Converting the dollar amounts to percentages, however, reveals a slightly different picture. The direct client fees have remained stable, insurance collections have increased from 19% to 23%, Medicaid has declined from 25% to 20% and Medicare has declined from 5% to 2%.

In order to more closely analyze these data, three hypotheses were developed and a multivariate analysis of variance with repeated measures was performed. In order to normalize the data, mean percentages, as opposed to mean dollar amounts were analyzed. The first hypothesis tested whether the three groups of CSBs were behaving in a similar fashion in the collection of fees over time. The results revealed no significant interactions between the groups over the nine periods for each of the various fee sources.

The second hypothesis examined mean group differences for each of the fee collections. The results indicate that group differences do exist, $F(2,19) = 3.20$, $p<.05$. A breakdown of fee collections on an individual basis revealed significant group differences for Medicaid (see Figure 1), $F(2, 19) = 4.672$, $p<.023$.

Insert Figure 1 about here

However, the individual breakdown for the remaining fee sources did not reveal significant group differences.

The third hypothesis tested changes in fee sources over time. Results indicated significant changes for Medicaid (see Figure 2), $F(2, 19) = 4.084$, $p<.001$ over time, and this trend could be fit with either a linear or quintic model. In addition, significant

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Insert Figure 2 about here

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results were obtained for insurance collections (see Figure 3), $F(2, 19) = 3.94$, $p<.037$ and this trend could be fit with a linear

model. The data failed to reveal any significant differences over time for the remaining fee sources.

Insert Figure 3 about here

The final test entailed an analysis of difference scores between insurance and Medicaid (see Figure 4) and insurance and

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Insert Figure 4 about here

Medicare. The three hypotheses were then tested with these scores. Difference scores for insurance and Medicaid indicate no interaction between the groups over time. However, group differences were significant, $F(2, 19) = 5.05$, $p<.017$ and trends over time (see Figure 5) were also significant, $F= 2.95$, $p<.004$.

Insert Figure 5 about here

These significant trends also could be fit with a linear model. Difference scores for insurance and Medicare revealed no interaction between groups over time, no group differences for fee collections, but a significant change over time, $F= 2.197$, $p<.031$ which could be fit with a quintic model.

Discussion

The results of this study reveal important shifts in fee collections in CMHCs in Virginia. These data replicate, in part,

NIMH (1980) national data from selected CMHCs which revealed a decrease in government (federal, state, and local) support for CMHCs. According to NIMH (1980) data, 80% of the CMHC budgets in 1969 were comprised of government funds while in 1976 the government allocations had dropped to 65.7%, and fees had risen from 16% in 1969 to 30.1% in 1976. Although the data from the present study reveals a decrease in government funding, this decrease was primarily due to cut backs in federal funds, as opposed to decreases in federal, state and local funds as had been the case with the NIMH data. In summary, the answer to the first question posed in this study reveals a shift toward increased fee collections, increased state funding, a slight increase in local funds, and a significant decrease in federal funds in Virginia.

The present study failed to replicate the observed shift in fee collections reported in the NIMH (1980) report. Those data revealed decreases in direct client fees from 7% in 1969 to 4% in 1976, increases in Medicaid from 2% to 10.4%, increases in insurance from 5% to 8%, and increases in Medicare from 1% to 2.4%. The data from the present study clearly indicate a significant increase in insurance reimbursements, a decrease in Medicaid collections and general stability for direct client and Medicare collections. More importantly, the results from Figures 2 and 3 predict that the increase in insurance collections and the decrease in Medicaid collections will continue in the coming quarters. The contradiction between the results of the present study and the NIMH (1980) data are quite noteworthy. One possible explanation is that Virginia CMHCs are different from those

studied in the NIMH (1980) report. A second explanation may be that during the past eight years a significant shift in fee collections has occurred nationwide. The contradictory results from these two studies highlight the need for further research in this area.

The implications from this study are significant. The shift toward increased insurance reimbursements may signify that more middle class clients are being treated in CMHCs, as the services to the poor are being dramatically reduced. In addition, these results may shed some light on the difficulties being encountered in the deinstitutionalization of patients from state hospitals. The high rate of readmissions to state hospitals may be due, in part, to the reduction of services to uninsured deinstitutionalized patients. It is important to note, however, that the data from this study examined finances, and fee collections. This study did not directly investigate the delivery of services in CMHCs, thus alternative interpretations of these data may exist.

One possible explanation for the increase in third party reimbursements is that CMHCs, over the past few years, have learned how to more efficiently collect insurance moneys from both clients and insurance companies. If this is the case, then the increase in third party reimbursements should have no effect on the delivery of services. As CMHCs learn to more effectively collect insurance moneys a leveling off of these collections should occur. It is hoped that future investigations will probe this question more closely.

Direct client fees comprise the largest proportion of fees (38%) but interpretation of these data are confounded because this source is collected from three different types of paying clients. The first group of clients pay on a sliding scale. The second group of clients may elect to pay the full amount and file with their insurance company at a later time. Finally, there is the group of clients whose only responsiblity is the co-payment of the usual and customary fees. In these cases, the CMHC takes the responsibility of filing the insurance claim for the patient and collecting the reimbursement directly from the insurance company. Thus, the figures for direct client fees must be further broken down before any meaningful interpretations are made of these data.

Another crucial point is that the amount of money collected by each CMHC may not reflect the number of people treated. For example, a given CMHC may receive $200 from BC-BS reimbursements and $100 from Medicaid. The larger BC-BS payment may indicate that the CMHC is treating a greater number of insured clients. An alternative explanation is that the given CMHC may be treating the same number of insured clients as Medicaid clients. Insurance reimbursements may simply be greater, per client, than the allowed Medicaid reimbursements. At the moment, no data exist to control for the number of clients being treated in each fee category.

One final point to be raised is that the lack of increases in Medicaid collections may be expected due to the cap imposed upon Medicaid by thegovernment regarding the number of visits per year for each client. However, private insurance companies place similar limitations regarding the number of visits per year.

The impact of shifts in fee collections upon the delivery of services in CMHCs is difficult to assess at this time. In order to test the many viable hypotheses posed by the results in this study future research should examine how shifts in revenue sources affect the delivery of services in CMHCs.

The third stage of our study, therefore, will involve the investigation of the impact of these shifts in funding sources upon the delivery of services. The shift in fee sources may be affecting the type of clients treated in CMHCs. Since more insurance money and less Medicaid is being collected, CMHCs may be treating clients who would ordinarily be serviced in the private sector. Perhaps the poor in the community are not being provided the mental health care they were originally intended to receive. Moreover, as CMHCs continue to seek third party reimbursements, they may tend to treat the insured, middle class clients as opposed to the uninsured, lower class clients and, as a result, slowly become "private" institutions.

In addition to investigating the type of clients treated, we will examine the impact of this shift in fee collections on the quality of treatment rendered. Uninsured, lower class clients, may be receiving differential treatment, possibly of lower quality, due to their limited payment capabilities. In particular, we will examine the relationship between the patients' payment (e.g., direct client, insurance, Medicaid, etc.) and variables such as length of treatment, type of treatment, type of therapist and length of time on a waiting list.

We hope that the present investigation will alert the mental health profession to the recent funding trends and to the potential detrimental consequences that can occur from these shifts in funding sources of CMHCs. We run the risk of significantly reducing the mental health care to the poorest sector of our society if a closer examination of these funding sources is not initiated immediately.

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Table 1

Revenue Sources for Mental Health Services in Virginia from 1980-1984

Source	1980 Dollars	%	1981 Dollars	%	1982 Dollars	%	1983 Dollars	%	1984 (Estimated) Dollars	%
State	$14,634,019	(40.5)	$16,163,341	(41.6)	$18,169,643	(42.6)	$20,487,776	(44.9)	$23,860,521	(47.3)
Local	10,721,104	(29.7)	11,722,727	(30.1)	12,548,004	(29.4)	14,344,073	(31.4)	15,417,060	(30.6)
Fees	5,080,684	(14.1)	5,576,169	(14.3)	7,129,301	(16.7)	7,613,216	(16.7)	8,527,495	(16.9)
Federal	5,166,265	(14.3)	4,949,077	(12.7)	4,303,917	(10.1)	2,904,580	(6.3)	2,231,957	(4.4)
Other	493,739	(1.4)	506,584	(1.3)	527,870	(1.2)	229,463	(0.5)	329,102	(0.6)
Total	$36,095,811	(100%)	$38,917,898	(100%)	$42,678,735	(100%)	$45,579,108	(100%)	$50,368,135	(100%)

Table 2

Percentage Increase (Decrease) of Revenue Sources for Mental Health Services in Virginia from 1980-1984

Source	1980-1981	1981-1982	1982-1983	1983-1984
State	10.5%	12.4%	12.7%	16.4%
Local	9.3%	7.0%	14.3%	7.4%
Fees	9.8%	27.8%	6.8%	12.0%
Federal	(0.4%)	(13.0%)	(32.5%)	(23.0%)
Total	7.8%	9.6%	6.8%	10.5%

Table 3

Mean and Percentage of Fee Collections by Quarter from 1982-1984

Source	1982 1st Q	1982 2nd Q	1982 3rd Q	1982 4th Q	1983 1st Q	1983 2nd Q	1983 3rd Q	1983 4th Q	1984 1st Q
Direct Client	$14,900	$15,600	$17,660	$18,460	$17,500	$18,000	$22,100	$22,740	$18,370
	(40%)	(38%)	(41%)	(42%)	(41%)	(38%)	(39%)	(41%)	(38%)
Insurance	8,170	7,730	9,480	8,370	8,570	9,650	11,060	10,920	10,841
	(19%)	(18%)	(23%)	(18%)	(18%)	(20%)	(23%)	(20%)	(23%)
Medicaid	7,810	7,830	7,650	7,030	7,310	7,600	7,050	7,120	7,800
	(25%)	(30%)	(22%)	(20%)	(23%)	(23%)	(16%)	(19%)	(20%)
Medicare	1,300	1,400	1,430	2,370	1,580	1,890	1,950	884	765
	(5%)	(5%)	(4%)	(5%)	(4%)	(5%)	(4%)	(2%)	(2%)
Other	12,270	5,630	5,230	3,680	3,720	4,620	7,220	5,650	4,981
	(19%)	(9%)	(9%)	(9%)	(9%)	(10%)	(12%)	(13%)	(13%)

Note: Insurance includes Blue Cross-Blue Shield (BC-BS), other commercial insurance, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Figure Captions

Figure 1. Mean percentage of fees collected for low, middle and high socio-economic Community Services Boards from the first quarter of fiscal year 1982 until the first quarter of the 1984 fiscal year.

Figure 2. Mean percentage of fees collected and predicted for Medicaid for all Community Services Boards for the first quarter of fiscal year 1982 until the first quarter of fiscal year 1984.

Figure 3. Mean percentage of fees collected and predicted for insurance for all Community Services Boards for the first quarter in fiscal year 1982 until the first quarter of fiscal year 1984.

Figure 4. Comparison of mean percentages of fees collected for insurance and Medicaid for the fisct quarter of fiscal year 1982 until the first quarter of fiscal year 1984.

Figure 5. Mean percentage differences and predicted differences for fees collected from insurance and Medicaid from the first quarter of fiscal year 1982 until the first quarter of fiscal year 1984.

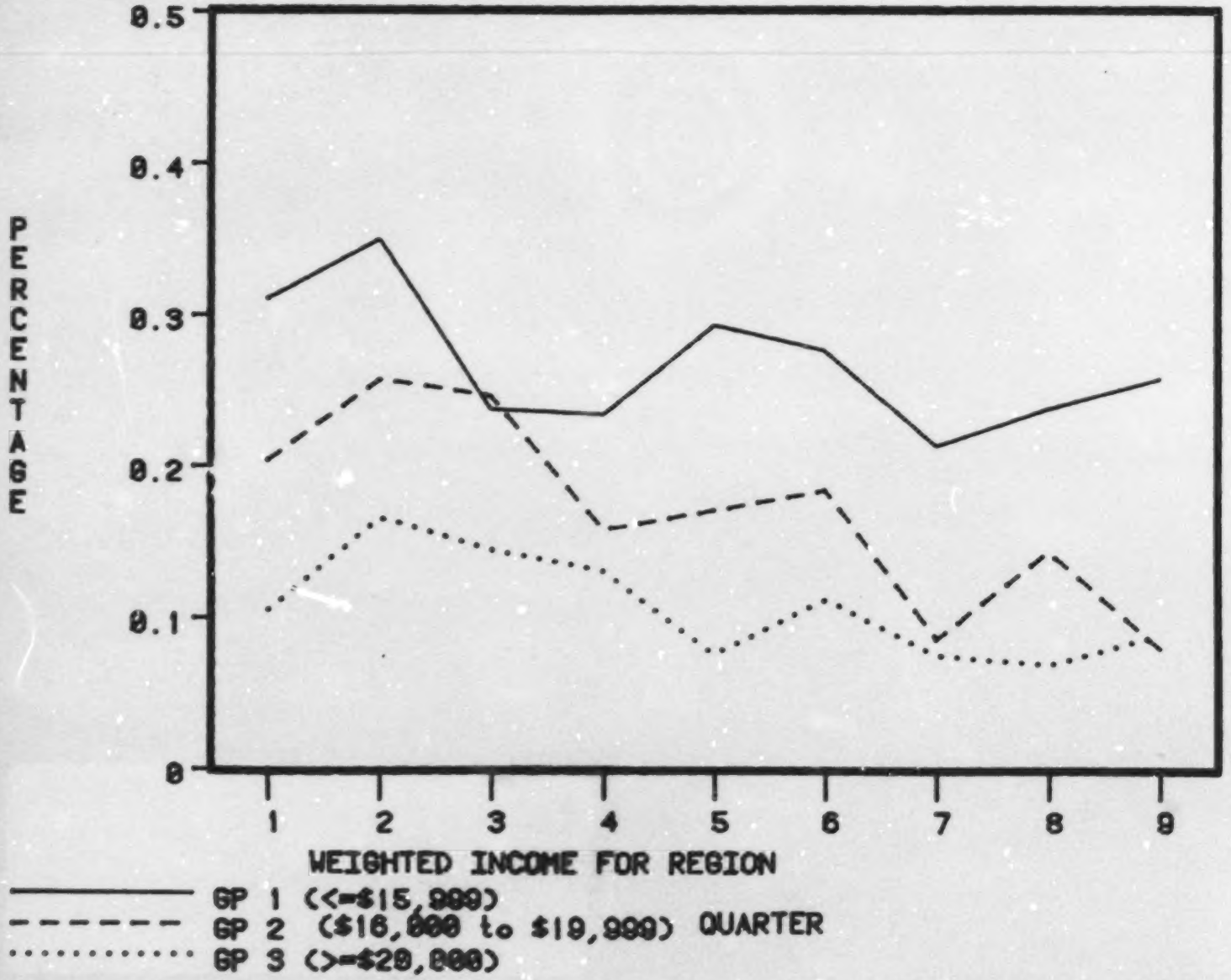
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FIGURE 1

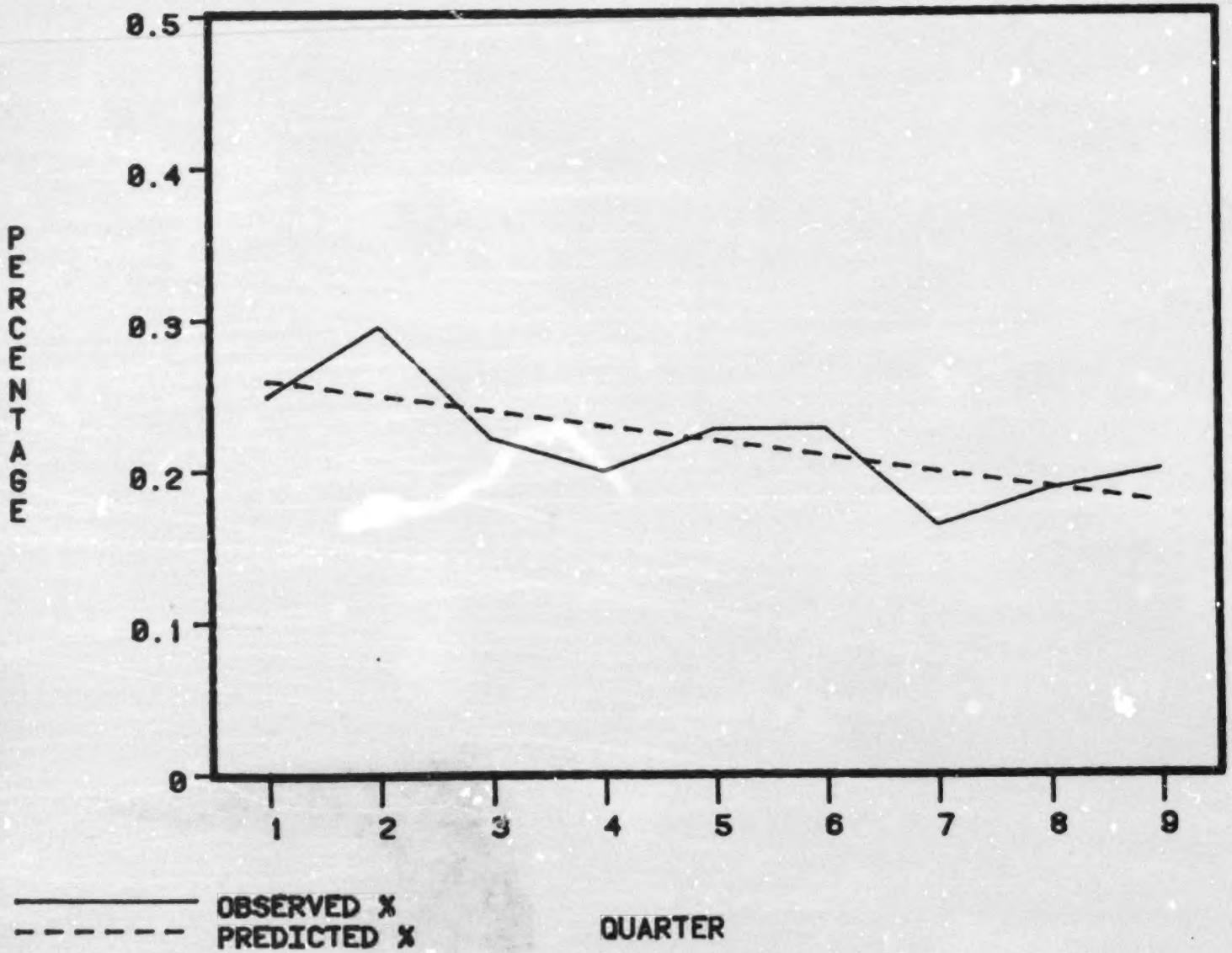
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FIGURE 2

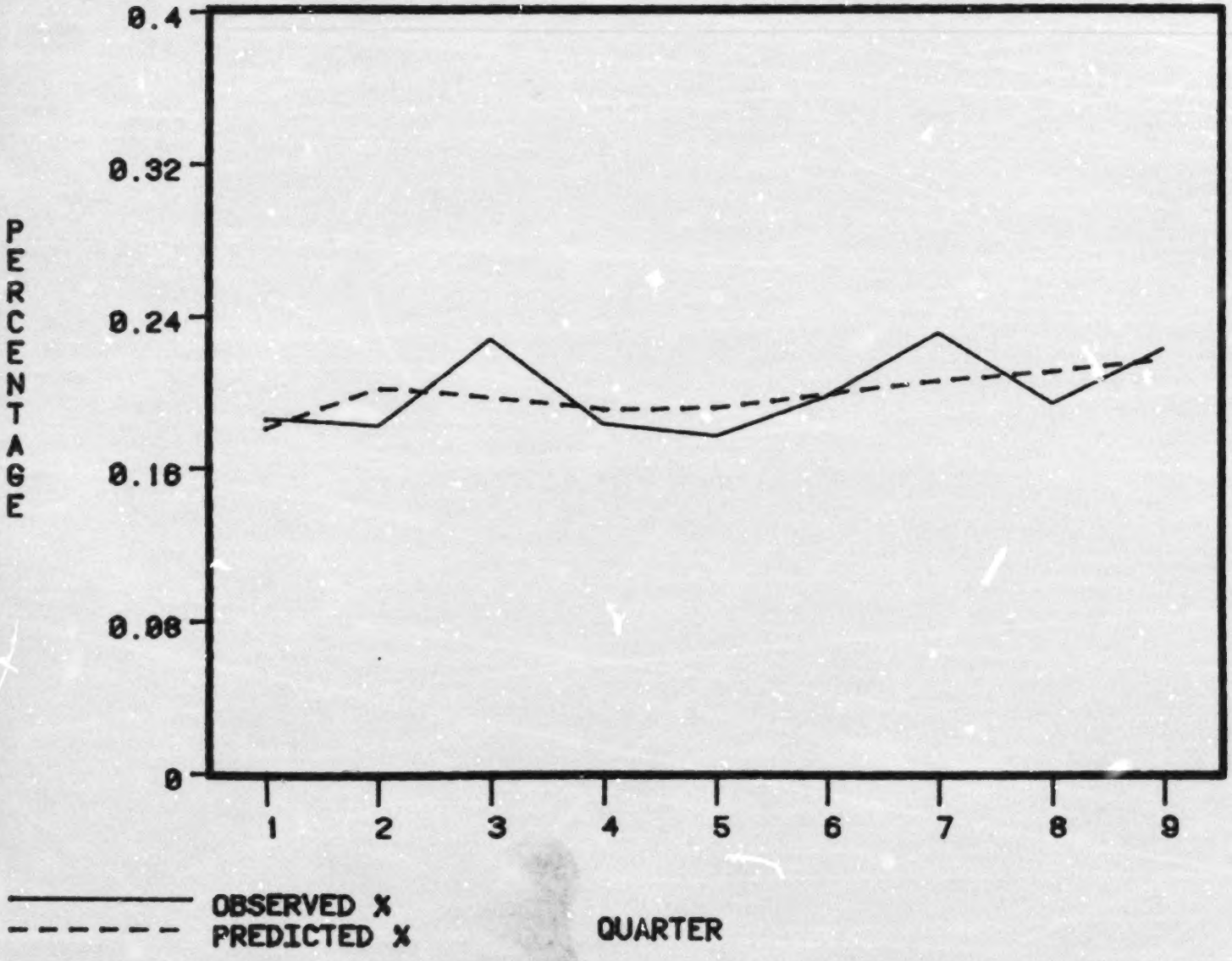
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FIGURE 3

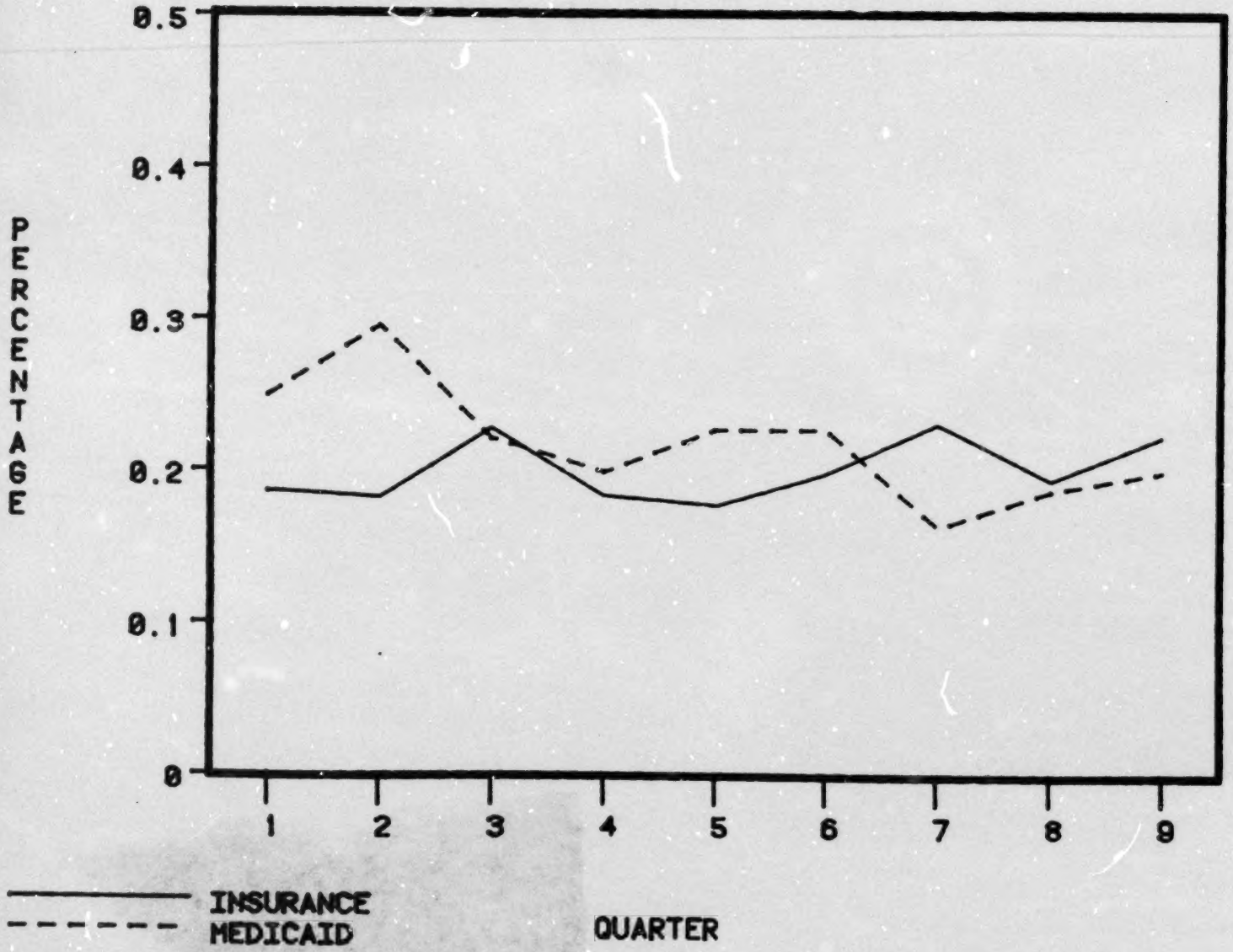
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FIGURE 4

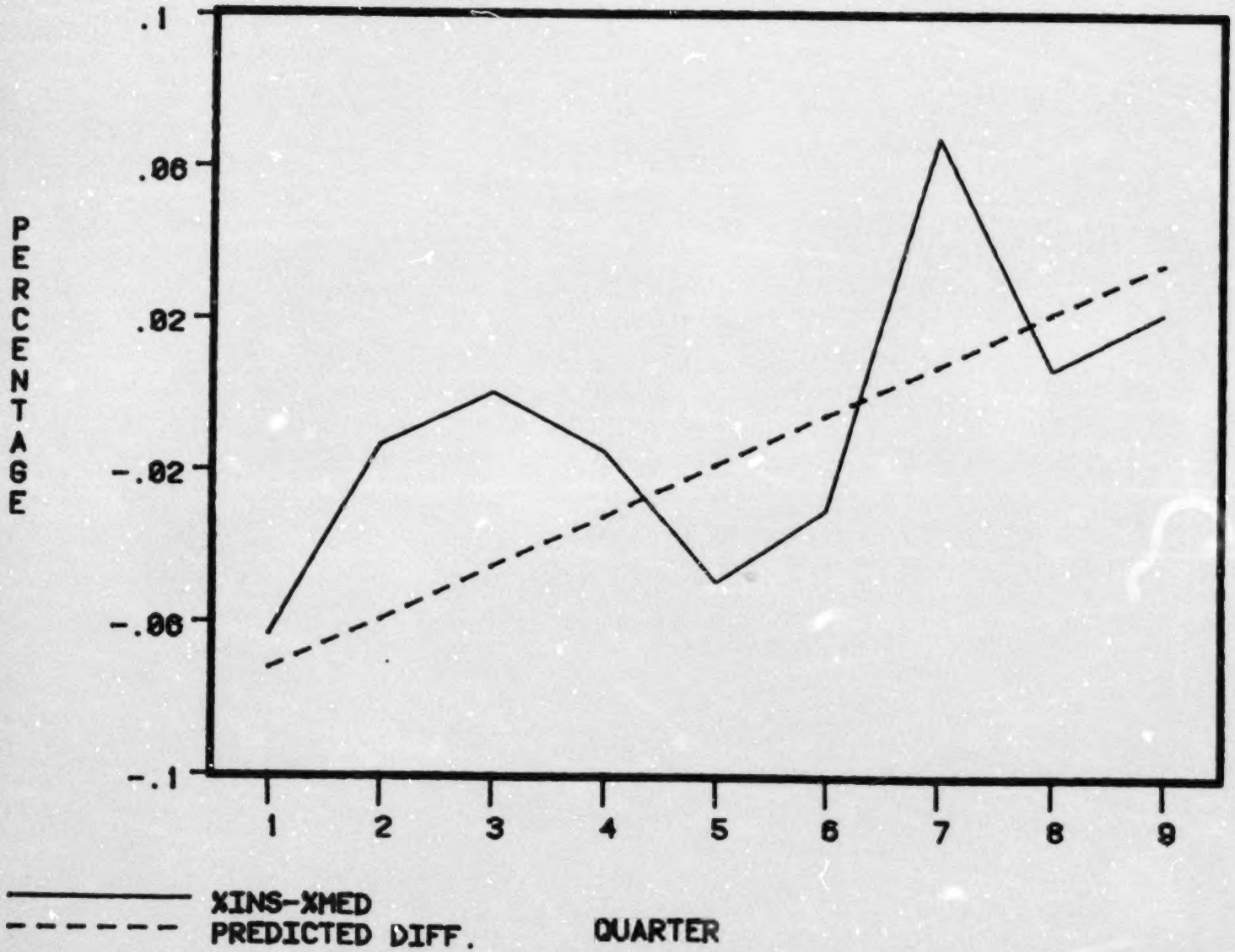
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FIGURE 5